FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to the State Children's Health Insurance Plans (SCHIP) and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs;

- Provide ***consistency*** across States in the structure, content, and format of the report;

- Build on data ***already collected*** by the Health Care Financing Administration (HCFA) quarterly enrollment and expenditure reports; **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) BadgerCare

SCHIP Program Type
X Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (October 1, 1999 – September 30, 2000)**

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Submission Date February 19, 2001

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program's changes and progress during Federal fiscal year (FFY) 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999, in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter NC for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility

NC

2. Enrollment process

NC

3. Presumptive eligibility

NC

4. Continuous eligibility

NC

5. Outreach/marketing campaigns

NC

6. Eligibility determination process

NC

7. Eligibility redetermination process

NC

8. Benefit structure

NC

9. Cost-sharing policies

The premium payment processing cycle has been changed from a 3-month system to a 2-month system.

10. Crowd-out policies

NC

11. Delivery system

- **HMO participation and service areas**

  - Since BadgerCare began in July 1999, there was a six-month period (July 1999 – December 1999) during which Medicaid HMOs were not obligated to cover BadgerCare recipients.

    However, due the collaborative relationship between the Department of Health and Family Services (DHFS) and HMOs, and the ongoing sharing of information about the development of the BadgerCare program between the DHFS and HMOs, 10 of the 18 Medicaid HMOs participating in managed care in CY 1999 signed contract amendments to cover BadgerCare recipients in the period July 1999 through December 1999. The following HMOs covered BadgerCare recipients in this period of time:

    - Atrium Health Plan
    - Compcare Health Plan
    - Dean Health Plan
    - Group Health Cooperative – Eau Claire
    - Humana
    - United Healthcare
    - Security Health Plan
    - Touchpoint Health Plan
    - Unity Health Plans
    - Valley Health Plan

    HMO participation was sufficient to cover 68 out of the 72 Wisconsin counties. Listed below is a table of BadgerCare HMO coverage compared to Medicaid HMO coverage in the July 1999 – December 1999 period.

HMO Participation in Managed Care Program July 1999 through December 1999	Medicaid	BadgerCare
Participating HMOs	18	10
Number of Mandatory HMO Enrollment Counties	47	30
Number of Partial Mandatory HMO Enrollment Counties, and Voluntary HMO Enrollment of fee-for-service (FFS) in Rest of County	16	20
Number of Voluntary HMO Enrollment Counties	5	16
Number of Partial Voluntary HMO Enrollment Counties, and FFS in Rest of County	2	2
Number of FFS Counties	2	4

For the CY 2000 – 2001 HMO contract, HMO participation in BadgerCare was required as a condition of Medicaid participation. The CY 2000 – 2001 HMO contracts were signed in March 2000. The following changes in HMO participation in Medicaid/BadgerCare occurred at that time and later in the year:

- ❖ Compcare did not contract for the Medicaid managed care program.
- ❖ Dean Health Plan eliminated a number of zip codes from their multi-county service area.
- ❖ Unity Health Plan reduced their multi-county service area to Dane County only.
- ❖ Valley Health Plan reduced their multi-county service area to Barron County only.
- ❖ Managed Health Services withdrew from Chippewa County.
- ❖ Group Health Cooperative – Eau Claire, Greater LaCrosse Health Plan, Primecare, and Touchpoint have increased their enrollment limit.
- ❖ Family Health Plan (FHP) of Milwaukee elected not to participate in the Medicaid/BadgerCare managed care program effective July 1, 2000. FHP had only 1,762 enrollees and did not cover BadgerCare recipients.

- ➢ As of October 2000, 15 HMOs are participating in Medicaid/BadgerCare managed care. The overall picture of managed care coverage is shown below:

HMO Participation in Managed Care Program – As of October 2000	
Participating HMOs	15
Number of Mandatory HMO Enrollment Counties	31
Number of Partial Mandatory HMO Enrollment Counties, and Voluntary HMO Enrollment of FFS in Rest of County	14
Number of Voluntary HMO Enrollment Counties	10
Number of Partial Voluntary HMO Enrollment Counties, and FFS in Rest of County	13
Number of FFS Counties	4

- ➢ At the end of the first operational year (June 2000) the DHFS temporarily decertified Group Health Cooperative – Eau Claire and Atrium Health Plan HMOs from selected zip codes surrounding the city of Menominee in Dunn County.

After Valley Health Plan withdrew from Dunn County earlier in the year, the aforementioned two HMOs have been attempting to contract with the Red Cedar clinic in Menominee. This clinic is the main physician facility in this city. Accordingly, the Menominee zip codes fell outside the 20-mile limit for access to a primary care provider, and were therefore taken out of the GHC-Eau Claire/Atrium service areas. GHC-Eau Claire and Atrium have now secured a contract with Red Cedar Clinic and those zip codes have now been recertified.

- The HMO program has increased its enrollment capacity since Compcare left the program effective March 31, 2000. Compcare had 5,785 BadgerCare enrollees, and 28,941 Medicaid enrollees for the month of March 2000.

The table below displays HMO enrollment as of July 1999, the beginning of the BadgerCare program, through November 2000, the most recent month's data on HMO enrollment. As the table illustrates, total HMO enrollment has increased from 180,963 in July 1999 to 233,854 in November 2000.

Month of HMO Enrollment	Medicaid Enrollees	BadgerCare Enrollees	Total
July 1999	180,963	0	180,963
November 2000	182,198	51,656	233,854

Total enrollment in BadgerCare in November 2000 is 77,047. Of these BadgerCare recipients, 51,656 are enrolled in HMOs. BadgerCare HMO enrollees represent 67 percent of total BadgerCare recipients. The remaining 25,391 BadgerCare recipients are receiving services in Medicaid FFS.

12. Coordination with other programs (especially private insurance and Medicaid)

NC

13. Screen and enroll process

NC

14. Application

NC

15. Other

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

BadgerCare enrollment as of September 30, 2000, included 20,371 children who were previously uninsured, and 3,749 low-income teenagers (OBRA). The total number of children with health coverage under BadgerCare was 24,120 - approximately 45 percent of the estimated baseline of uninsured low-income children.

BadgerCare Enrollment/BadgerCare Eligible Remaining Uninsured
As of September 30, 2000

	Parents	Children	Total
Uninsured Under 200% of Federal Poverty Level (FPL) (Based on 1997 and 1998 FHS Sample)*	90,000	54,000	144,000
Enrolled in BadgerCare	50,627	20,371	70,998
Low Income Teenagers (OBRA Expansion)		3,749	3,749
Total BadgerCare	50,627	24,120	74,747
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/ Medicaid Coordination		22,963	22,963
Total BadgerCare and Medicaid Increase	50,627	47,083	97,712
As percentage of uninsured under 200% FPL*	56.3%	87%	68%
Estimated BadgerCare Eligible Remaining Uninsured	39,373	6,917	46,288
As percentage of uninsured under 200% FPL	43.7%	13%	32%

The net FFY 00 increase in BadgerCare enrollment and reduction in the rate of uninsured low-income children is shown in the table below.

* Based on the most recent Family Health Survey data for the years 1997 and 1998, it is estimated that there were 54,000 uninsured children living in households with income below 200 percent of the FPL.

Net BadgerCare Enrollment/BadgerCare Eligible Remaining Uninsured In FFY 00

	Parents	Children	Total
Uninsured Under 200% of FPL (Based on 1997 and 1998 FHS Sample)*	90,000	54,000	144,000
Enrolled in BadgerCare	33,774	14,073	47,847
Low Income Teenagers (OBRA Expansion)		-381	-381
Total BadgerCare in FFY 00	33,774	13,692	47,466
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/ Medicaid Coordination in FFY 00		20,410	20,410
Total BadgerCare and Medicaid Increase in FFY 00	33,774	34,102	67,876
As percentage of uninsured under 200% FPL in FFY 00	37.5%	63.2%	47.1%
Estimated BadgerCare Eligible Remaining Uninsured (Based on cumulative enrollment as of September 30, 2000)	39,373	6,917	46,288
As percentage of uninsured under 200% FPL	43.7%	13%	32%

Wisconsin Medicaid eligibility files, residing in the MMIS, are the data source for enrollment data.

The State has utilized the most current Family Health Survey sample available to produce the estimated baseline. The FHS was began 1989, and is conducted on a continuous basis, collecting information every month. The survey is conducted by trained interviewers who speak with the household member most knowledgeable about the health and insurance coverage of all household members.

The survey results are representative of Wisconsin household residents, who constitute approximately 97 percent of all persons residing in the state. Non-household residents, including persons living in nursing homes, dormitories, prisons, and other institutions constitute the remaining 3 percent who are not represented in the survey.

The Confidence Interval for the estimated baseline is (+/-) 9,000.

* Based on the most recent Family Health Survey data for the years 1997 and 1998, it is estimated that there were 54,000 uninsured children living in households with income below 200 percent of the FPL.

The baseline estimate represents estimated number of uninsured low-income children based on survey responses. The estimate should not be treated as a precise result as it is derived from a sample.

The Wisconsin Family Health Survey uses a larger random sample for Wisconsin than does equivalent uninsured data from the Census Bureau. In addition, the FHS specifically asks questions about being uninsured, unlike the Census Bureau. The Census Bureau arrives at its estimate through the residual method, which simply assumes that anyone who did not report having health insurance is actually uninsured. The lack of a direct question about being uninsured is a serious omission, which can result in an overestimate of the proportion uninsured.

While we recognize that there are some limitations in reporting progress in this way, given the turnover in the caseload and the comparison of historical data about the uninsured to current enrollment data, we are fortunate in Wisconsin to have this baseline population data. The Wisconsin Family Health Survey data presents a more accurate picture of the uninsured in Wisconsin than national studies or Census Bureau surveys. We believe it stands as a national model for its methodology and consistency, in part because it uses a larger sample, and asks more direct questions about insurance status than other instruments.

Progress in reducing the number of uninsured children since September 2000

Since September 2000 through November 2000, an additional 1,489 children have enrolled in BadgerCare; an additional 2,600 children have enrolled in Medicaid; and an additional 811 parents have enrolled in BadgerCare.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

BadgerCare enrollment as of September 2000 is 24,120 children. In addition, 22,963 children have enrolled in Medicaid as a result of the BadgerCare outreach and coordination with the Medicaid program, through September 2000. This represents a net increase in Medicaid children in FFY 00 of 20,410. Thus, a total of 47,083 children have enrolled in BadgerCare/Medicaid since the implementation of BadgerCare, which represents 87 percent of the baseline estimate of uninsured children below 200 percent FPL.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Medicaid enrollment of children is growing because of BadgerCare. Outreach efforts and simplified enrollment policies encouraged enrollment of the target, uninsured population. Over 20,000 new Medicaid recipients (low-income, uninsured) have been enrolled since the full implementation of BadgerCare in July 1999.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter NC (for no change) in column 3.*

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
BadgerCare will increase the number of insured children and parents in Wisconsin.	Expect to see the full budgeted BadgerCare enrollment (as reflected in the Wisconsin Section 1115 Waiver) during CY 2000 - 48,800 recipients: 22,700 children, or 42% of baseline estimate of 54,000 uninsured low income children; 26,100 parents, or 29% of baseline estimate of 90,000 uninsured low income parents.	Data sources: Estimates of uninsured children and parents under 200% FPL in Wisconsin are taken from the combined 1997 and 1998 sample of the Wisconsin Family Health Survey. Recipients enrolled in BadgerCare taken from the MMIS (HMKR481Q report). Methodology: Measure progress in reducing the number of uninsured children and parents in Wisconsin by comparing BadgerCare enrollment to the universe of the uninsured low-income children/ parents. Numerator: As of September 1999, BadgerCare had enrolled 10,428 children, 16,853 parents, and 2,553 new Medicaid children due to BadgerCare. Through September 2000, BadgerCare had enrolled 24,120 children, 50,627 parents, and 22,963 new Medicaid children due to BadgerCare. The net increase in BadgerCare in FFY 00 is 13,692 children, 33,774 parents, and 20,410 new Medicaid children. Denominator: Based on the Wisconsin Family Health Survey there are 54,000 uninsured children under 200% FPL; there are 90,000 uninsured parents under 200% FPL. Progress Summary: In FFY 00, BadgerCare provided 34,102 children with coverage, or 63% of the low-income uninsured children in Wisconsin. BadgerCare also provided 33,774 parents with coverage, or 38% of the low-income uninsured children in Wisconsin.

Additional Narrative for Program Experience Through November 2000

BADGERCARE ENROLLMENT AT THE END OF NOVEMBER 2000			
Recipient Category	**Parents**	**Children**	**Total**
Wisconsin Uninsured under 200 FPL	90,000	54,000	144,000
BadgerCare	51,438	22,020	73,458
OBRA Accelerated Children		3,589	3,589
Total BadgerCare (with OBRA)	51,438	25,609	77,047
New Medicaid Children		25,563	25,563
Total BadgerCare and Medicaid	51,438	51,172	102,610
As Percentage of Uninsured under 200% FPL	57%	95%	71%

Current Wisconsin Medicaid and BadgerCare covers children in the following family-related categories:

Category of Children		**FPL**
Medicaid:	AFDC- Related up to Medically Needy Level	68% FPL
Medicaid:	Healthy Start Children Under 6	185% FPL
Medicaid:	OBRA Children Born After September 1983	100% FPL
BadgerCare:	Children under 19	200% FPL

The following data through November 2000 shows the current count of children enrolled in Healthy Start and BadgerCare categories by age:

Healthy Start	**Count**	**BadgerCare**	**Count**
Age 0-5	58,562	Age 0-5	966
Age 6-18	37,124	Age 6-12	13,287
		Age 13-18	11,356
Total	**95,686**		25,609

As of November, 2000 there are an additional 96,368 children under age 19 covered under the Medicaid sub-programs that are tied to the AFDC and AFDC–related rules that still exist as Medicaid eligibility categories. We do not break down this category by age in routine reports.

BadgerCare's coverage of parents of children was established in the context of Wisconsin's comprehensive Medicaid coverage of non-disabled adults under 65 and very high rate of insured residents.

Wisconsin Medicaid covers non-disabled custodial parents in AFDC-related families at an average income standard of 55 percent of the FPL, and children only in families with income above 55 percent but below 68 percent FPL. This custodial parent income standard compares favorably with the national median income standard of 45 percent FPL for AFDC-related custodial parents. In addition, pregnant women are covered up to 185 percent FPL.

In CY 1999, 96 percent of Wisconsin's residents had health insurance. This is the highest rate in the United States.

Given this background, BadgerCare's coverage of parents was specifically targeted to the truly needy - those uninsured parents losing Medicaid as a result of increased income due to welfare reform; and, those parents not previously involved in public assistance who do not have access to affordable health insurance.

BadgerCare's coverage of parents during this reporting period has been funded with Title XIX funds, not Title XXI funds.

TABLE 1.3

Strategic Objective	Performance Goals	Performance Measures and Progress
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Improve outreach and increase enrollment of Medicaid eligible children and parents	Improve the rate at which persons entitled to Medicaid apply for and enroll in Medicaid through integrated Medicaid/ BadgerCare outreach and coordination between BadgerCare and Medicaid. Growth rates in Medicaid TANF/ Healthy Start have	Data sources: MMIS Monthly Eligibility Report (481Q) Methodology: Measure the growth in Healthy Start Medicaid eligibles in the 12 months of FFY 2000 BadgerCare operations (October 1999 – September 2000). Growth in Healthy Start Medicaid eligibles prior to the July 1999 BadgerCare implementation was flat. Growth in FFY 2000 is due to Medicaid/BadgerCare outreach and the impact of BadgerCare enrollment and coordination with Medicaid. Numerator: September, 1999 Healthy Start Medicaid Children – 73,427 September 2000 Healthy Start Medicaid Children – 94,386 Increase in Healthy Start Medicaid Children in FFY

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
	been either negative or nominally positive in recent years.	2000 – 20,959 Denominator: Irrelevant Progress Summary: In FFY 2000, Medicaid/ BadgerCare outreach and the impact of BadgerCare enrollment produced an increase of 20,959 Healthy Start Medicaid Children.

Additional Narrative for Program Experience Since September 2000

Through November 2000, an additional 2,600 Healthy Start Medicaid children were enrolled due to Medicaid/BadgerCare outreach and the impact of the BadgerCare enrollment process.

In FFY 2000, AFDC-related Medicaid experienced a net increase of 2,423 recipients.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OTHER OBJECTIVES – PREVENTION OF CROWD-OUT		
Crowd-out will not occur	Automated edits and procedures in the CARES eligibility determination system and the MMIS will prevent BadgerCare enrollment of families with: • Current coverage; • Coverage in the 3 months prior to application; • Current access to ESI subsidized by the employer at 80% or more of premium costs; and	Data sources: CARES eligibility determination application denial edits; MMIS HIPP eligibility determination denial edits. Methodology: Report aggregate statistics on number of BadgerCare applicants denied eligibility due to current/3 month retroactive insurance coverage; current/18 month retroactive access; HIPP applicants denied eligibility due to 6 month retroactive coverage by 60%-80% subsidized coverage. Numerator: Coverage denials; Access denials; HIPP retroactive coverage denials. Denominator: Total applicants for BadgerCare Progress Summary: The automated edits described above are operational. Detailed statistics on the edit "hits" are not available at this time. However, other evidence supports the fact that Wisconsin is meeting this performance goal.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
	• Access in the 18 months prior to application or HIPP enrollment if covered by ESI subsidized by the employer between 60% and 80% of monthly premium.	As of November, 2000, 87% of recipients enrolled in BadgerCare are at or below 150% FPL. These families are the most likely income group to be uninsured. Based on the survey of employers that Wisconsin does to verify BadgerCare enrollees current insurance status, 64% of employers surveyed indicate that the employee has no access to family coverage.

Additional Narrative on Potential Barriers to Preventing Crowd-out/Future Plans for Monitoring

Barriers to meeting goals of preventing crowd-out in BadgerCare:

- Current federal policy on CHIP buy-in of employer-sponsored insurance (ESI) prevents states from buy-in if the recipient's employer pays less than 60 percent of the family premium. This lower limit to ESI subsidy rates artificially lowers the target population of BadgerCare recipients who could be bought in to ESI in a cost-effective manner.

Future plans for preventing/monitoring of BadgerCare crowd-out:

- Request HCFA lower its threshold for ESI from 60 percent to 50 percent.
- Implement Wisconsin Family Health Survey refinements relating to employment status, income and access to health insurance.
- Continue education and outreach for eligibility workers, employers with low-income employees.
- Survey employers based on national models (Institute for Health Policy Solutions/ RAND).
- Survey enrollees to provide more detailed information regarding decision-making and participation with regard to employer-sponsored insurance.

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
BadgerCare enrollees will report satisfaction with access to care in terms of waiting time for appointments, ability to get referrals, etc.	BadgerCare HMO enrollees will report the same level of satisfaction with access to care, based on standard indices, as TANF/ Healthy Start Medicaid HMO enrollees	**NC** Data sources: CAHPS Survey performed by 3rd party contractor. Methodology: In CY 2000, the CAHPS Survey for Medicaid HMOs will sample both AFDC-Related/Healthy Start Medicaid HMO enrollees and BadgerCare HMO Enrollees, and report on enrollee satisfaction for the 2 samples. Numerator: Composite indices for enrollee satisfaction with access for separate AFDC-Related/Healthy Start Medicaid HMO enrollee and BadgerCare HMO enrollee samples. Denominator: Not relevant Progress Summary: CY 2000 CAHPS survey has not been implemented yet. Since BadgerCare started in July 1999, there was insufficient enrollment data and time for BadgerCare enrollees to be included in the CY 1999 CAHPS survey.
OTHER OBJECTIVES – POSITIVE IMPACT ON DELIVERY SYSTEMS		

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
BadgerCare will result in greater Medicaid HMO capacity in Wisconsin	The BadgerCare program will increase the number of enrollees in Medicaid HMOs in contrast to previous declining growth in enrollment.	Data sources: MMIS HMO enrollment data Methodology: Growth in Medicaid HMO enrollment in FFY 00. Numerator: Medicaid HMO enrollment as of September 2000. Denominator: Medicaid HMO enrollment as of September 1999 Progress Summary: Medicaid HMO enrollment for AFDC-related/Healthy Start women and children and BadgerCare as of September 1999 was 186,024. Medicaid HMO enrollment for AFDC-Related/ Healthy Start women and children and BadgerCare as of September 2000 was 233,283. This represents an increase in Medicaid HMO enrollment of 47,259; or a 25% increase from the previous FFY.
		Additional Narrative to reflect progress through January 2001. By January 2001, Medicaid HMO enrollment had grown to 237,609 .

The following strategic objectives relate to increasing access to care, use of preventive care, and other objectives relating to quality of care.

These strategic objectives, and their performance goals and measures, differ somewhat from the objects/goals/measures that were previously described in the CHIP State Plan Amendment (SPA).

The SPA strategic objectives used a limited set of measures from Wisconsin's annual HMO Utilization/ Survey Report, HMO Targeted Performance Improvement Measures (TPIM), and the overall Quality Assurance and Performance Improvement (QAPI) initiatives. However, since HMOs are required to report a separate annual Utilization/Survey Report for BadgerCare enrollees, to apply QAPI to their BadgerCare enrollees, and since the TPIMs apply to all HMO enrollees, the full set of measures will be used for BadgerCare.

The SPA performance goals compared BadgerCare HMO enrollee experience with Medicaid FFS experience. Since the SPA was submitted, however, Wisconsin has discontinued comparing Medicaid HMO enrollee experience to Medicaid FFS experience. This is because the Medicaid HMO program

is now a statewide program and there are limited comparable FFS populations to use as a basis of comparison. Therefore, the performance goals for BadgerCare HMO enrollees will be defined as met if, in the areas of access, use of preventive care, and other quality measures, their experience is equivalent to the experience of the TANF/Healthy Start pregnant women/child HMO enrollee experience.

With regard to the TPIMs, BadgerCare and TANF/Healthy Start HMO enrollees are combined. The performance goals are standards based on national/state goals.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OTHER OBJECTIVES:	***Quality of Care –Preventive and Chronic Disease State Care Performance Measures***	
	Targeted Performance Improvement Measures	
Childhood immunizations	90% of enrolled children will be fully immunized by age 2 years.	**NC** Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: 3 Hep. B, 4 DTaP/DTP/DT, 2 Hib, 3 IPV (or OPV for 1999 services only–IPV only for services in 2000), and 1 MMR, each reported as individual numerators, contraindicated items can automatically be excluded. Combination rate including the following: 3 Hep. B, 4 DTaP, 2 Hib, 3 IPV/OPV, 1 MMR. Child must have different dates of service in the reporting year. At least one of the Hepatitis B vaccinations must fall on or between the child's sixth month and second birthday. Denominator: All children enrolled on their second birthday, with the second birthday falling in the reporting year and at least ten months of continuous enrollment with not more than one break in enrollment of 45 days prior to the child's second birthday and who received the required immunizations. Progress Summary: Measure specifications completed. This is a modification from the previous measure, updating the numerators to reflect current CDC-ACIP recommendations and with revised enrollment criteria in the denominator. Data for CY 2000 will be available in August 2001.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Lead Toxicity	2000: 65% of all eligible enrollees to have had lead toxicity screenings. The objective for CY 2001 is 85%. Two rates must be reported, one for one year olds and one for two year olds.	**NC** Data sources: Encounter data, medical records, public health screening data. Methodology: Service utilization measure. Numerator: The number of children in the denominator who had a blood lead screening performed by age one and age two years. Criteria: a) encounter with CPT-4 code 83655 or, b) medical record review data indicating blood lead test. Denominator: **L-1 Denominator for lead screening (For children from 6 to 16 months of age, inclusive)**: Any child that turned 16 months of age (inclusive to the last day of the sixteenth month) during the reporting year and was enrolled in the HMO at their first birthday and had ten months continuous enrollment with no more than one break in enrollment of up to 45 days prior to reaching 16 months of age. **L-2 Denominator (For children from 17 to 28 months of age, inclusive)**: The number of children 17 to 28 months (inclusive) of age who had their second birthday during the reporting year and were enrolled in the HMO at their second birthday with ten months continuous enrollment with no more than one break in enrollment of up to 45 days prior to reaching 28 months of age. The age cohort for this measure begins with the first day of the seventeenth month of life and includes the time period up to the last day of the 28th month of life. Progress Summary: Revised age cohort specifications implemented for 2000-01 HMO contract.
		Data for CY 2000 will be available in August 2001.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Preventive dental care.	For CYs 2000 and 2001 enrollees will receive preventive dental services at a rate greater than or equal to 110% of the preventive dental services rate for FFS recipients. Comparative preventive dental service rates are reported in the Wisconsin Medicaid Comparison Report: 1996.	**NC** Data Sources: Encounter data or medical records. Methodology: Utilization measure. Numerator: The number of enrollees age 3 to 21 and age 21 and over who have had at least one preventive dental service during the reporting year, separated by county of residence of the enrollee. A member is identified as having a dental visit if he or she has had a claim/encounter that includes both a clinical oral evaluation and prophylaxis as defined by the following CDT-2 Current Dental Terminology (CDT) codes. Denominator: The number of children age 3 to 21 and age 21 and over enrolled in the HMO during the reporting year. Progress Summary: Baseline year for performance standard revised for implementation in 2000-2001 HMO contract. Data for CY 2000 will be available in August 2001.
Follow-up care after inpatient mental health care.	Improve rate of follow-up care by 7 and 30 days post discharge by 10% over baseline year (2000) in 2001. This improvement goal is based on a 10% improvement in adverse outcomes.	**NC** Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: The number of discharges in the denominator that were followed by an ambulatory mental health encounter or day/night treatment within 7 and 30 days of hospital discharge. Ambulatory follow-up encounters are identified by the CPT-4 codes or UB-92 revenue codes specified. Denominator: Discharges for enrollees age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified below, and who were continuously enrolled without breaks for 30 days after discharge. Progress Summary Data for Baseline CY 2000 will be available in August 2001.
Follow-up care after inpatient treatment for substance abuse.	To increase the rate of ambulatory follow-up treatment within 7 and 30 days of discharge for individuals with specific substance abuse disorders, by 10 percentage points each year. This improvement goal is based on a 10% improvement in adverse outcomes	**NC** Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: The number of discharges in the denominator that were followed by an ambulatory substance abuse encounter within 7 and 30 days of discharge. Denominator: Discharges for enrollees age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating substance abuse, and who were continuously enrolled without breaks for 30 days after discharge. Progress Summary Data for baseline CY 2000 will be available in August 2001.
Outpatient Management of Diabetes	To measure and improve performance of outpatient management services for people with Type 1 or Type	**NC** Data sources: Encounter data, medical record review. Methodology: Utilization measure. Numerators:

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
	2 diabetes. The goal for 2000 is establishment of baseline data for the provision of the following services to enrollees with diabetes: 1. Hemoglobin A1c (HbA1c) testing, CPT-4 code 83036; and, 2. Lipid profile testing, CPT-4 code 80061, 83720 or 83721.	**Hemoglobin A1c:** HbA1c tests conducted in the reporting year. Administrative data or medical record review may be used to identify services. CPT-4 code 83036 or medical record lab report including result for service provided in the reporting year. **Lipid profile:** LDL test done during the reporting year or year prior to the reporting year. Administrative data or medical record review may be used to identify services. CPT-4 code 80061, 83720 or 83721 or medical record lab report including result. Denominator: Enrollees age 18-75 years as of December 31 of the reporting year. Must be continuously enrolled for ten months with no more than one gap in enrollment of 45 days in the reporting year. Those who were dispensed insulin and/or oral hypoglycemics/antihyperglycemics during the reporting year on an ambulatory basis, or had at least two encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one encounter in an acute inpatient or emergency room setting during the reporting year with diagnosis of diabetes. Progress Summary Data for baseline CY 2000 will be available in August 2001.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Access to services and other utilization measures Clinical and non-clinical priority areas.***		
Clinical priority areas	Performance goals may be set by the HMO.	**NC** Clinical priority areas are those identified by the state in the contract that the HMO may choose to measure and implement performance improvement projects in. Optional clinical topic areas include: 1. prenatal services; 2. identification of adequate treatment for high-risk pregnancies, including those involving substance abuse; 3. evaluating the need for specialty services; 4. availability of comprehensive, ongoing nutrition education, counseling, and assessments; 5. Family Health Improvement Initiative: Smoking Cessation; 6. children with special health care needs; 7. outpatient management of asthma; 8. the provision of family planning services; 9. early postpartum discharge of mothers and infants; 10. STD screening and treatment; and 11. high volume/high risk services selected by the HMO. <u>Progress Summary</u>

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		Data for CY 2000 will be available in October 2001.
Non-clinical priority areas	Performance goals may be set by the HMO.	**NC** Non-clinical priority areas are those identified by the state in the contract that the HMO may choose to measure and implement performance improvement projects in. Optional non-clinical topic areas include: 1. Grievances, appeals and complaints; and 2. Access to and availability of services. In addition, the HMO may be required to conduct performance improvement projects specific to the HMO and to participate in one annual statewide project that maybe specified by the Department. Progress Summary Data for CY 2000 will be available in September 2001.
OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Enrollee satisfaction***		
CAHPS survey of BadgerCare HMO enrollee satisfaction.	Aggregation of baseline data on overall satisfaction. BadgerCare HMO enrollee satisfaction will be equivalent to TANF/Healthy Start HMO enrollee satisfaction	**NC** CAHPS survey data aggregation methodology to be implemented by third-party contractor. Progress Summary CAHPS data on BadgerCare HMO enrollees for CY 2000 will be available in August 2001
Satisfaction with referral for mental health/substance	Aggregation of baseline data on overall satisfaction	**NC** This performance improvement area establishes a

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
abuse care subset.	with referral for MH/SA services. BadgerCare HMO enrollee satisfaction will be equivalent to TANF/Healthy Start HMO enrollee satisfaction	baseline measure of enrollee satisfaction with referral for mental health and substance abuse services based on enrollee responses to the following specific questions. These questions will be included in the standardized Consumer Assessment of Health Plan (CAHPS) survey administered by the Department. This measure assesses the number of enrollees indicating they "need help with an alcohol, drug or mental health problem" as the denominator and the number of enrollees that indicate they did or did not actually get counseling or help as the numerator. The results will be aggregated by the Department or its contractor and reported to the respective HMO. The Department may specify minimum performance levels and require that HMOs develop action plans to respond to performance levels below the minimum performance levels. Progress Summary CAHPS data on BadgerCare HMO enrollees for CY 2000 will be available in August 2001
OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Standardized utilization survey measures***		
Women's health measures: maternity care.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number of all deliveries with live birth and inpatient days by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All C-section and vaginal deliveries with live

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		birth. Denominator: Not applicable. Not reported as a percentage Progress: Measure is implemented.
Women's health measures: C-sections.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number of deliveries by Cesarean section with live birth and inpatient days by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All c-section deliveries with live birth. Denominator: All live births. Progress: Measure is implemented.
Women's health measures: VBAC.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number of vaginal births after Cesarean section (VBAC) with live birth and inpatient days by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Vaginal deliveries after previous c-section. Denominator: All live births. Progress: Measure is implemented.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Women's health measures: substance abuse treatment concurrent with pregnancy/ delivery	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number of women who delivered live birth and had substance abuse services. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All deliveries with live birth for enrollees receiving SA services in the 300 days prior to delivery. Denominator: Not applicable. Not reported as a percentage Progress: Measure is implemented. Data for first 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Women's health measures: HIV testing at delivery.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number of women who delivered live birth and had HIV testing. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All deliveries with live birth for enrollees receiving HIV testing in the 300 days prior to delivery. Denominator: Not applicable. Not reported as a

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		percentage. Progress: Measure is implemented.
Women's health measures: mammography.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number women that had a mammogram in the reporting year by age cohort. Measure includes numerator for number of women with malignancy of the breast. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator(s): Female enrollees receiving at least one mammogram. Number of tests detecting malignancy. Denominator: Unduplicated female enrollees by age cohort. Progress: Measure is implemented.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Women's health measures: Pap test (cervical cancer screening).	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number women that had a Pap test in the reporting year by age cohort. Measure includes numerator for number of women with malignancy of the cervix and/or uterus. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Female enrollees receiving at least one Pap test. Number of tests detecting malignancy. Denominator: Unduplicated female enrollees by age cohort. Progress: Measure is implemented.
Child health measures: HealthCheck screens.	Trend and monitor utilization. Goal: 80% of eligible children under age 21 receive required screens. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of children that received a comprehensive HealthCheck screening by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Number of unduplicated children under age 21 that received at least one comprehensive HealthCheck. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Child health measures: HealthCheck screens.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks number children referred for follow-up care as the result of HealthCheck screens, excluding vision, dental and audiology services by age cohort under age 21 years. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Children referred for follow-up care as the result of HealthCheck screens, excluding vision, dental and audiology services by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Child health measures: well-child non-HealthCheck screens.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of children that received a child health non-HealthCheck screening by age cohort under age 21 years. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: The number of children that received a child health non-HealthCheck screening by age cohort under age 21 years.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Child health measures: other non-HealthCheck ambulatory health services.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of children that received a non-HealthCheck ambulatory health service by age cohort under age 21 years. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: The number of children that received a non-HealthCheck ambulatory health service by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Child health measures: number of children with diagnosis of asthma.	Trend and monitor prevalence. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees under age 21 years with diagnosis of asthma in the reporting period. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees under age 21 years

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		with diagnosis of asthma. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Child health measures: number of children with at least one inpatient stay for a diagnosis of asthma.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees under age 21 years with at least one inpatient stay for a diagnosis of asthma in the reporting period. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees with at least one inpatient stay for a diagnosis of asthma. Denominator: All enrollees under age 21 years with diagnosis of asthma. Progress: Measure is implemented.
Mental health/ substance abuse: outpatient evaluations.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving outpatient mental health and/or substance abuse evaluations by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving outpatient

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		mental health and/or substance abuse evaluations. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Mental health/ substance abuse: outpatient treatment.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving outpatient mental health and/or substance abuse treatment by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator(s): Unduplicated enrollees receiving outpatient mental health and/or substance abuse treatment. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Mental health/ substance abuse: inpatient readmissions for treatment.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving inpatient mental health for the same diagnosis within one-year by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving inpatient mental health for the same diagnosis within one year. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Primary and Specialty care: ER visits without inpatient admission.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving care in an emergency department of an acute care hospital not resulting in an inpatient admission by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in an emergency department of an acute care hospital not resulting in an inpatient admission.
		Denominator: Not applicable. Not reported as a percentage.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
		Progress: Measure is implemented.
Primary and Specialty care: Home care	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving care in a home care setting by age cohort. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in a home care setting. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.
Primary and Specialty care: Care in a primary care clinic, vision care, audiology, and dental clinic.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving care in each listed care setting. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in each listed care setting. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Hospital utilization data: number of discharges, ALOS, total hospital days, for maternity, surgical, medical, psychiatric and AODA services.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	**NC – Encounter Data being validated. Validation expected in mid-2001. CY 2000 Survey/Utilization Data for January – June 2000 being validated. Validation expected in January 2001.** Tracks the number of unduplicated enrollees receiving care in an inpatient acute care hospital setting for each listed care type. Data sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in an inpatient acute care hospital setting for each listed care type. Denominator: Not applicable. Not reported as a percentage. Progress: Measure is implemented.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Performance goals relating to reducing the number of uninsured children, SCHIP enrollment, and increasing Medicaid enrollment are being met, as previously described in Section 1.3 above.

Performance goals relating to access to care are prima facie being met, since 69 percent of BadgerCare recipients are enrolled in Medicaid/BadgerCare HMOs and the Wisconsin Medicaid/BadgerCare Managed Care program has a history of providing increased access to services compared to FFS. More definitive data on access to care will be provided by the CY 2000 HMO Survey/Utilization Report, due in finalized form in August 2001, and ongoing HMO Encounter Data.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

There are no specific issues Wisconsin agreed to assess that were not included as a strategic objective in our State plan for our S-CHIP program (BadgerCare).

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The following are future performance measurement activities relating to BadgerCare:

- CY 2000 HMO BadgerCare Survey/Utilization Report and Preventive Care Objectives, which report data on indicators used to measure access to care and quality of care. Final report due from HMOs August 11, 2001.

- HMO Encounter Data will be validated for reliability and completeness for CY 2000 and will be used to measure access to care and quality of care. Validation will be completed by the mid 2001.

- CAHPS Survey for CY 2000 will be used to measure recipient satisfaction with HMO access to care and quality of care. Final report expected August 2001.

- Employer survey to measure extent, if any, of "crowd-out" due to BadgerCare. Survey to be performed in early 2001 and completed in late 2001.

- Ongoing HMO performed clinical care studies, DHFS medical care audits, etc. that are components of Managed Care Quality Assurance/Performance Improvement (QAPI) program.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

None available.

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

BadgerCare has a family coverage component, as HCFA defines family coverage in Section 2105(c)(3) of Title XXI.

Our family coverage component is called the Health Insurance Premium Payment (HIPP) program, and employer-sponsored insurance premium assistance program, where BadgerCare families have met the Title XXI cost-effectiveness test – i.e., the cost of buying in the family to employer-sponsored insurance is less than the cost of enrolling children only in the BadgerCare program. Below is the overall description of HIPP, including family coverage

The Wisconsin Medicaid fiscal agent, EDS, receives daily notifications of the employment status of new and ongoing BadgerCare recipients from the state's eligibility determination (CARES) system. EDS staff contact the employers of all applicants to verify current access to family health insurance subsidized by the employer. Verification is done through mailing of the Employer Verification of Insurance Coverage (EVIC) forms to the employers and telephone follow-up.

At this point, EDS has received verification that the family has access to employer-subsidized family health care coverage, subsidized at less than 80 percent but more than 60 percent of the premium cost. The family is BadgerCare eligible on a FFS basis. The next step is to determine whether it is cost-effective to buy the available employer-sponsored insurance for them through the HIPP Program based on the Title XXI cost-effectiveness test. If it is not cost-effective, the family chooses between the BadgerCare HMO programs available to recipients living in their service area or remain in BadgerCare FFS if no HMOs are available. If only one HMO is available the family has a choice between choosing to enroll in the HMO or remaining in FFS.

Employers are contacted to obtain specific information about their insurance plans so that:

- Cost effectiveness can be determined. EDS determines the cost of the family premium, how much the employer pays, and what types of services the plan covers.

- Premium payments can be made. EDS determines whether the employer, insurer or recipient will be reimbursed, as well as frequency and payment method.

- Full insurance information is added to the recipient's eligibility record for coordination of benefits activities in claims processing. This information includes group and subscriber numbers, begin and end dates of coverage and indicators of services covered by the plan.

- The following information is collected and retained in the HIPP Program database:

  - Length of employer health insurance coverage;

  - Employer payment frequency and method of payment;

  - Premium amounts;

  - Employer contribution amounts and coverage; and

  - Who is covered under the insurance.

- BadgerCare families in Wisconsin are only eligible to participate in HIPP if:

  - they had no employer-sponsored group coverage within the previous six months (exceptions are allowed if prior coverage was involuntarily terminated by other than the current employer), and

  - the employer contributes at least 60 percent, but less than 80 percent, of the premium share for family coverage (families whose employer contributes more than 80 percent of the premium share are not eligible for BadgerCare; families whose employer contributes less than 60 percent of the premium are eligible for BadgerCare without HIPP).

- When the information needed for the cost-effectiveness determination is received, the cost effectiveness comparison is made between:

  - The cost of BadgerCare HMO enrollment for the children (plus certain additional services covered on a FFS basis, such as family planning, dental, or chiropractic), up to the full Medicaid level of services; and

  - The cost of the BadgerCare portion of the employer-subsidized insurance premium (including the cost of co-insurance and deductible reimbursement to the providers), plus the cost of wraparound services to provide the full Medicaid level of services. In addition, the state includes administrative costs for data collection, processing, notifications, telephone charges and other

maintenance costs of the HIPP process in its cost effectiveness calculation.

- If cost of ESI is less than enrollment of children only in BadgerCare, the state claims cost for purchase of ESI under Title XXI for parents.
  Another calculation is made to compare costs of ESI vs. enrollment of the family in BadgerCare. If ESI is less expensive, the state charges parents at regular FMAP.

  The Health Insurance Premium Payment (HIPP) Program - Benefits Equivalency, Limitation on Copayment Liability, Coordination with CHIP

  Benefit Equivalency: BadgerCare recipients receive the full range of Wisconsin Medicaid covered services. BadgerCare recipients enrolled in employer-sponsored insurance through HIPP also receive the full range of Wisconsin Medicaid covered services. Recipients enrolled in ESI receive BadgerCare services on a FFS basis from Medicaid providers for those services not covered by the ESI or services covered by the ESI but for which maximum limits have been reached. This is called "wraparound."

  Limitation on Copayment Liability: BadgerCare recipients enrolled in employer-sponsored insurance through HIPP do not pay for the coinsurance and deductibles charged by the ESI. ESI providers submit claims for coinsurance and deductibles to EDS, the Wisconsin Medicaid fiscal agent, which are then paid on a FFS basis. BadgerCare recipients enrolled in employer-sponsored insurance are required to pay the standard Medicaid copayments, which are nominal. Medicaid copayments are only applied to non-pregnant adults; in addition, certain services are exempt from copayments which include emergency services, family planning services/supplies, therapies over the Medicaid prior authorization limit, and other essential services.

  Coordination with CHIP: The family is enrolled in the employer-provided family health insurance plan at the earliest available open enrollment period of the health plan. If the earliest available open enrollment period is less than six months in the future, the family receives benefits in BadgerCare FFS until they can be enrolled in the employer-provided family health insurance plan. If the earliest available open enrollment period is six or more months in the future, the family is enrolled in the Medicaid HMO program until they can be enrolled in the employer-provided family health insurance plan.

2. How many children and parents were ever enrolled in your SCHIP family coverage program during FFY 2000 (October 1, 1999 – September 30, 2000)?

Number of parents 7
Number of children 7

3. How do you monitor cost-effectiveness of family coverage?

We have not been able to measure cost-effectiveness of family coverage as we have only had nine families involved in the program for a few months. We will measure this in the future.

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

Wisconsin implemented the HIPP program as part of Wisconsin's SCHIP plan called BadgerCare. BadgerCare began July 1, 1999. The BadgerCare Health Insurance Premium Payment (HIPP) program helps low-income working families with children receive health care through employer-sponsored health insurance plans. The HIPP program determines whether the state will pay for BadgerCare recipients' costs to enroll into an employer- sponsored family health insurance plan.

The goals of the BadgerCare HIPP program include:

- To provide continuity of care with health care providers as families move to private insurance as their incomes increase.
- To promote comparable access to health care for all employees regardless of coverage available due to employment status or support provided by BadgerCare.
- To coordinate with employers to supplement, not supplant, employer insurance pools.
- To maximize the use of private support, in place of public funds, for BadgerCare.

Each BadgerCare recipient's employer is asked to complete an Employer Verification of Insurance Coverage (EVIC) form. Information provided by the employer on this form will help BadgerCare verify the employee's access to health insurance offered by the employer, and will also provide information about the costs of the employer-sponsored health plans to determine qualifications for HIPP.

BadgerCare HIPP requirements include:

- Family members must not have been covered by the employer plan in the past six months;
- The employer plan must meet HIPAA standards (e.g., major medical plan);
- The employer must pay between 60 to 80 percent of the cost of the monthly premium for a family health insurance plan; and;

- The employer –sponsored plan must be cost-effective.

Cost–effectiveness is determined by comparing the cost for BadgerCare HMO coverage to the cost of the premium subsidy, plus any necessary benefit and copayment wraparound costs (services not covered by the employer's plan), plus the state's cost of administering the program.

If the employer provides two or more cost-effective health plans, the family will be asked to choose the health plan they prefer. The state will work with both the employee and the employer to set up the most convenient way to pay the employee portion of the health insurance premium.

2. How many children and parents were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of parents 11
Number of children 15

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

BadgerCare is intended to help families in the workforce receive affordable health insurance until they can obtain insurance from their employment. BadgerCare eligibility policies are designed specifically to prevent supplanting or "crowd-out" of private insurance.

Crowd-out may occur in the following situations:

- Families drop employer-sponsored coverage as a direct result of the extension of BadgerCare (subsidized coverage not previously available).

- Families enrolled in BadgerCare choose to remain in BadgerCare despite access to employer-sponsored coverage.

- Employers reduce or drop their contribution to family coverage in direct response to BadgerCare eligibility policies.

2. How do you monitor and measure whether crowd-out is occurring?

System edits and protocols in CARES and MMIS monitor and prevent BadgerCare enrollment of families with the following:

- current HIPAA coverage;

- coverage in the 3 months prior to application;
- current access to ESI subsidized by the employer at 80 percent or more of premium costs;

- access in the 18 months prior to application; or

- direct applicant eligibility to HIPP enrollment if covered by ESI subsidized by the employer between 60 and 80 percent of the monthly premium.

See the Attachment 1 "EVIC Statistics."

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

We have no evidence that BadgerCare is causing employers to drop insurance coverage.

As of September 2000, approximately 90 percent of recipients enrolled in BadgerCare are below 150 percent FPL. These families are the most likely income group to be uninsured.

Attachment 2 is a summary of information from the CARES system about BadgerCare case closure codes that may relate to trends in the private insurance market. This table, prepared for HCFA as part of Wisconsin's annual CHIP waiver report submitted on April 1, 2000, provides a summary of various closure reasons. We continue to review CARES data, including denial and closure codes, to see if it is possible to track patterns of employer coverage through the eligibility determination computer system.

The health insurance segment of the 1999 Family Health Survey was recently released and shows a mixed picture on the number of uninsured in Wisconsin. A copy of the report is attached. The proportion of uninsured for the entire year has remained at 4 percent since 1998. Another 8 percent of Wisconsin residents were uninsured for part of 1999 compared to 6 percent in 1998. The 1999 survey found 93 percent of Wisconsin household residents were insured at the time of the survey compared to 94 percent in 1998.

The 1999 survey did not reflect the impact of BadgerCare because the program was just beginning in mid-1999. As a result, the real impact of BadgerCare will not be seen until the 2000 survey results are compiled. The 1999 survey was conducted over the course of the entire year with interviews conducted each month, which also reduces the impact of the introduction of BadgerCare during 1999.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

BadgerCare eligibility is limited to families whose income does not exceed 185 percent of the FPL. Very few families with income at this level have access to private health coverage. The attached "EVIC Statistics Analysis" indicates a small number of BadgerCare recipients have access to employer-sponsored insurance where the employer contributes between 60 to 80 percent of the monthly premium (see Attachment 3).

Once eligible, families may remain in BadgerCare until their income exceeds 200 percent of the FPL. Employer-subsidized health insurance is not common among families with income at or below these amounts

The State performs research to determine if a BadgerCare family should be enrolled in the HIPP or if a family member has access to a family group health plan where the employer pays 80 percent or more of the premium.

BadgerCare crowd-out policies are publicized using a variety of media and access points. Television and radio spots were initially used to familiarize people with the general concept of BadgerCare. An ongoing, extensive distribution of program brochures to counties, health care facilities, employment agencies, employers and eligibility determination sites provides a source of BadgerCare crowd-out policy and eligibility information. In addition, a toll-free telephone hotline has been established to respond to specific eligibility and application questions.

Employer training sessions on BadgerCare policy and eligibility have been conducted in conjunction with private employer associations for the purpose of explaining crowd-out policy and the HIPP program. Staff of community agencies and advocacy agencies have received training on these policies so that they can help explain program requirements to their customers.

BadgerCare crowd-out policy and eligibility information is continuously available on the BadgerCare website, including, employer fact sheets and eligibility criteria for families with access to employer-sponsored coverage.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The program design, integrating SCHIP with Medicaid, and offering coverage for parents as well as children is the key to reaching the target population. Success is measured by progress in enrollment of the target population.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

No data on this.

3. Which methods best reached which populations? How have you measured effectiveness?

No data on this.

2.5 Retention:

1. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

A mail-in review has been implemented, and the premium payment process has been simplified.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers

___ Renewal reminder notices to all families

___ Targeted mailing to selected populations, specify population _____

___ Information campaigns

X Simplification of re-enrollment process, please describe A mail-in review has been implemented as well as an easier premium payment method.

___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____

X Other, please explain The Milwaukee Process Improvement Committee is identifying and resolving procedural barriers that may exist.

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

The mail-in review form.

5. **What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.**

No data on this.

2.6 Coordination between SCHIP and Medicaid:

1. **Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.**

NC

2. **Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.**

NC

3. **Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.**

NC

2.7 Cost Sharing:

1. **Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP?** No. **If so, what have you found?**

2. **Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP?** Not applicable. **If so, what have you found?**

2.8 Assessment and Monitoring of Quality of Care:

1. **What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.**

- Preliminary utilization data for BadgerCare enrollees, for January – June 2000, as previously described in Section 1.3 above. Will be validated by January 2001.

- Monthly HMO Encounter Data for CY 2000 dates of service, through the November 2000 submission. HMO encounter data being validated by the DHFS for reliability and completeness, to be completed by mid-2001.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Wisconsin's overall QAPI strategy is presented Table 1.3 earlier in this report. It incorporates all the required elements in the HCFA proposed rule on managed care and some that are not required by federal rule, but that have evolved over time within the state's Medicaid managed care program. Among the state-specific key elements are:

- Significant use of on-going input from stakeholders including consumers, providers, MCOs and other state divisions and bureaus in contract development.

- State-specific standardized performance measures developed based on population health needs and DHFS health improvement objectives.

- Targeted performance improvement measures with mandatory reporting.

- Optional clinical and non-clinical priority areas for assessment/improvement.

- Consumer safeguards for enrollees in MCOs that utilize "demand management" systems such as nurselines or other forms of telephone triage.

- Voluntary development and dissemination of "best practices" among MCOs.

- Advocacy within MCOs for enrollees.

Well-baby Care, Well-Child Care, and Immunizations

The DHFS maintains ongoing monitoring and coordinating activities in relation to EPSDT, pregnant women, and maternal and infant health.

Regarding well-baby and well-child care, the DHFS has sponsored quarterly regional meeting of HMOs, providers, community-based organizations, public health agencies, and advocates to improve EPSDT screening rates and coordination among agencies. The DHFS also sponsored a statewide conference on improving EPSDT rates in April 2000. The conference was planned by a consortium of HMOs, advocates, and public health agencies and was attended by over 300 people.

HMOs are reviewed annually to determine if they have met their contractual requirement to provide 80 percent of the recommended EPSDT screens for their enrollees. Funds are recouped from HMOs based on the percentage difference between their actual screening rate and the 80 percent contracted screening rate.

In addition, the required annual HMO Utilization/Survey Report has indicators for utilization rates for well-baby/well-child visits and other types of ambulatory pediatric child health care visits.

Pregnant women and maternal and infant health subjects are discussed periodically at the ongoing HMO regional forums with the intent of monitoring activities and improving coordination between HMOs and other local health agencies and community-based organizations.

The Immunization Rate is one of the Targeted Performance Improvement measures in the CY 2000 – 2001 HMO contract. The objective in the contract for HMOs is to increase to 90 percent the proportion of enrolled children two years of age who are fully immunized.

The HMO contract contains requirements for MOUs between HMOs and Prenatal Care Coordinating Agencies to assure coordination of care, and for referrals by HMOs to WIC and other Title V agencies. Coordination between HMOs and local public health agencies is encouraged by the contract.

Mental Health, Substance Abuse Counseling and Treatment

The DHFS maintains ongoing monitoring and coordinating activities in relation to mental health, substance abuse counseling and treatment services.

First, HMOs must meet requirements relating to their mental health, substance abuse counseling and treatment provider networks before they are certified as a Medicaid/BadgerCare provider in their proposed service areas. HMO mental health, substance abuse counseling and treatment provider networks are mapped against the zip codes in their proposed service area. Their networks must be sufficient to have a mental health, substance abuse counseling and treatment provider within 35 miles of all the zip codes in their service area. Any zip code that falls outside this 35 mile standard is removed from the HMO proposed service area.

An additional certification requirement is that HMOs must have signed Memoranda of Understanding (MOUs) with County Mental Health Agencies in order to assure access to and coordination of services, establish communication between the HMO and the County, and to prevent duplication of services. Second, mental health and substance abuse (MH/SA) are two of the Targeted Performance Improvement Measures (TPIM) in the CY 2000 – 2001 HMO contract. HMOs must meet the following standards related to MH/SA services:

- HMOs must increase the rate of ambulatory follow-up treatment within 7 and 30 days of hospital discharge for treatment of selected mental health disorders by 10 percentage points each CY (2000 – 2001).

- HMOs must increase the rate of ambulatory follow-up treatment within 7 and 30 days of hospital discharge for treatment of selected substance abuse disorders by 10 percentage points each CY (2000 – 2001).

Third, HMOs must report various utilization measures relating to MH/SA services on a semi-annual basis in their Survey/Utilization Reports. These measures are monitored by the DHFS as indications of performance in providing access to and quality of MH/SA care. These utilization measures include the following:

- Number of unduplicated pregnant enrollees who delivered and received SA services.

- Number of unduplicated enrollees receiving outpatient MH/SA evaluation services from a MH/SA provider and number of evaluations for these enrollees.

- Number of unduplicated enrollees diagnosed with a non-organic, non-substance abuse mental health disorder receiving MH ambulatory services and/or MH day treatment services and the number of visits for these enrollees from MH and/or general/family physicians or general internal medicine physicians.

- Number of unduplicated enrollees with a SA diagnosis receiving SA ambulatory and/or SA day treatment services from SA providers and/or general/family physicians or general internal medicine physicians.

- Number of unduplicated enrollees readmitted to an inpatient hospital for selected MH disorders within one year.

Dental Services

The DHFS maintains ongoing monitoring and coordinating activities in relation to dental services. In the Wisconsin Medicaid/BadgerCare Managed Care program, dental services are an optional service for HMOs to provide. Currently, the DHFS only authorizes HMOs to provide dental services in Kenosha, Milwaukee, Racine, and Waukesha counties.

First, HMOs must meet requirements relating to their dental provider networks before they are certified as a Medicaid/BadgerCare provider in their proposed service areas. HMO dental provider networks are mapped against the zip codes in their proposed service area. Their networks must be sufficient to have a dental provider within 35 miles of all the zip codes in their service area. Any zip code that falls outside this 35 mile standard is removed from the HMO proposed service area.

Second, dental service is one of the Targeted Performance Improvement measures in the CY 2000 –

2001 HMO contract. The goal in the contract for HMOs is that they provide preventive dental services at a rate greater than or equal to 110 percent of the preventive dental service rate for Medicaid/BadgerCare FFS. This goal applies to CY 2000 and CY 2001.

Third, the DHFS is planning, undertaking, or has implemented a number of activities to assess access to HMO dental services in the four southeastern counties. These activities include:

- A telephone survey of the HMOs' listed dental providers, to assess the accuracy of the listing.
- Review of the 1999 CAHPS survey for results on the six questions relating to dental survey.
- Ongoing review of HMO encounter data.
- Ongoing review of HMO complaint/grievance logs transmitted to the DHFS.
- Planned clinical audit of dental services.

Vision Care

The DHFS maintains ongoing monitoring and coordinating activities in relation to vision services. This is accomplished through routine monitoring of HMO encounter data, review of quarterly HMO complaint/grievance reports, and review of HMO contract monitor telephone log.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The plan for future monitoring/assessment of quality of care received by SCHIP enrollees is the implementation of already planned activities:

- Completion of CY 2000 and CY 2001 HMO Survey/Utilization Reports for BadgerCare.
- Completion CY 2000 CAHPS Survey with a sampling of BadgerCare recipients.
- Review specialized reports from the HMO Encounter Data Reporting System after the system has been validated for reliability and completeness.
- Continue with the ongoing array of QAPI activities described in 2.8.2 above.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter >NA= for not applicable.

1. Eligibility

NC

2. Outreach

NC

3. Enrollment

BadgerCare enrollment as of September 30, 2000, included 20,371 children who were previously uninsured, and 3,749 low-income teenagers (OBRA). The total number of children with health coverage under BadgerCare was 24,120 – approximately 45 percent of the estimated baseline of uninsured low-income children.

In addition, 20,949 children who were previously uninsured were enrolled in Healthy Start and 2, 019 children in AFDC or AFDC-related Medicaid. The total number of children enrolled below 200 percent of poverty as of September 30, 2000, was 47,083 – approximately 87 percent of the baseline of uninsured low-income children. (See the chart located in section 1.2 BadgerCare Enrollment/BadgerCare Eligible Remaining Uninsured; as of September 30, 2000.)

4. Retention/disenrollment

NC

5. Benefit structure

NC

6. Cost-sharing

Disenrollment due to non-payment of premium:

The table below lists the number of cases and individuals that were disenrolled from BadgerCare from January – June 2000 for failure to pay their premiums. The number of recipients disenrolled for this reason is declining due to an improved premium notification process that provides recipients with a more timely notice of when premiums are due.

The percentage of premium-paying BadgerCare recipients who are disenrolled from BadgerCare for failure to pay their premiums is approximately 2 percent.

Cases and Individuals Who Were Terminated Due to BadgerCare Premium Non-Payment		
January – June 2000		
Quarter Month	**Cases Closed**	**Individuals Closed**
January 2000	200	340
February 2000	190	325
March 2000	118	201
April 2000	82	176
May 2000	93	200
June 2000	88	178
Six Month Total	771	1,420

- MMIS and MEDS

BadgerCare Premiums Subsystem: A problem with the BadgerCare premium notification and collection subsystem found in FFY 00 was that notifications were not synchronized between CARES and MMIS. There was a lengthy period of time between when the recipient received the premium coupon and when the premium was actually due. The full process took approximately three months. Any number of things could have changed in that time that affected the premium, including changes in eligibility status, changes in premium amount, etc.

As of October 2000, the premium process cycle was shortened to two months in the MMIS, and the reminder letter was eliminated since it had no clear effect on the timeliness of payments. Now, the coupon is sent to the recipient the day after the CARES adverse action date (which determines whether the recipient remains eligible for the next month) and the premium will be due the 10th of the month following the adverse action. If no payment is received by the adverse action date of the month the premium is due, the client will receive a termination letter. A one-page letter was sent to premium paying recipients to notify them of the scheduled change. A reconciliation process was implemented to eliminate any further synchronization issues.
The system definition, detailed system design, and the coding for these changes in the MMIS

occurred during the April – June 2000 quarter. It was completed in the July – September 2000 quarter

7. Delivery systems

HMO participation and service areas

- Since BadgerCare began in July 1999, there was a six-month period (July 1999 – December 1999) during which, Medicaid HMOs were not obligated to cover BadgerCare recipients.

  However, due the collaborative relationship between the DHFS and HMOs, and the ongoing sharing of information about the development of the BadgerCare program between the DHFS and HMOs, 10 of the 18 Medicaid HMOs participating in managed care in CY 1999 signed contract amendments to cover BadgerCare recipients in the period July 1999 through December 1999. The following HMOs covered BadgerCare recipients in this period of time:

  Atrium Health Plan
  Compcare Health Plan
  Dean Health Plan
  Group Health Cooperative – Eau Claire
  Humana
  United Healthcare
  Security Health Plan
  Touchpoint Health Plan
  Unity Health Plan
  Valley Health Plan

HMO participation was sufficient to cover 68 out of the 72 Wisconsin counties. Listed below is a table of BadgerCare HMO coverage compared to Medicaid HMO coverage in the July 1999 – December 1999 period.

HMO Participation in Managed Care Program July 1999 through December 1999	Medicaid	BadgerCare
Participating HMOs	18	10
Number of Mandatory HMO Enrollment Counties	47	30
Number of Partial Mandatory HMO Enrollment Counties, and Voluntary HMO Enrollment of FFS in Rest of County	16	20
Number of Voluntary HMO Enrollment Counties	5	16
Number of Partial Voluntary HMO Enrollment Counties, and FFS in Rest of County	2	2
Number of FFS Counties	2	4

- For the CY 2000 - 2001 HMO contract, HMO participation in BadgerCare was required as a condition of Medicaid participation. The CY 2000 - 2001 HMO contracts were signed in March 2000. The following changes in HMO participation in Medicaid/BadgerCare occurred at that time and later in the year:

  - Compcare did not contract for the Medicaid managed care program.
  - Dean Health Plan eliminated a number of zip codes from their multi-county service area.
  - Unity Health Plan reduced their multi-county service area to Dane county only.
  - Valley Health Plan reduced their multi-county service area to Barron county only.
  - Managed Health Services withdrew from Chippewa county.
  - Group Health Cooperative - Eau Claire, Greater LaCrosse Health Plan, United Healthcare, and Touchpoint have increased their enrollment limit.
  - Family Health Plan (FHP) of Milwaukee elected not to participate in the Medicaid/BadgerCare managed care program effective July 1, 2000. FHP had only 1,670 enrollees and did not cover BadgerCare recipients. Family Health Plan was unable to provide HMO encounter data according to specified DHFS requirements. They were also unable to fulfill other DHFS reporting requirements.

- More recently, the following changes have occurred:

  - Four HMOs have formally requested increases in enrollment and/or service areas.
  - One HMO has informally requested an increase in their enrollment limit and service area effective January 2001.
  - The three largest of the four HMOs who requested increases have over 25 percent of their total Medicaid and BadgerCare population as BadgerCare enrollees.

- As of October 2000, 15 HMOs are participating in Medicaid/BadgerCare managed care. The overall picture of managed care coverage is shown below:

HMO Participation in Managed Care Program As of September 2000	
Participating HMOs	15
Number of Mandatory HMO Enrollment Counties	31
Number of Partial Mandatory HMO Enrollment Counties, and Voluntary HMO Enrollment of FFS in Rest of County	14
Number of Voluntary HMO Enrollment Counties	10
Number of Partial Voluntary HMO Enrollment Counties, and FFS in Rest of County	13
Number of FFS Counties	4

- At the end of the first operational year the DHFS temporarily decertified Group Health Cooperative – Eau Claire and Atrium Health Plan HMOs from selected zip codes surrounding the city of Menominee in Dunn county.

  After Valley Health Plan withdrew from Dunn County earlier in the year, the aforementioned two HMOs are attempting to contract with the Red Cedar clinic in Menominee. This clinic is the main physician facility in this city. Accordingly, the Menominee zip codes fell outside the 20 mile limit for access to a primary care provider, and were therefore taken out of the GHC-Eau Claire/Atrium service areas. These zip codes are now represented by FFS providers.

- The HMO program has increased its enrollment capacity since Compcare left the program effective March 31, 2000. Compcare had 5,785 BadgerCare enrollees, and 28,941 Medicaid enrollees for the month of March 2000.

  The table below displays HMO enrollment as of July 1999, the beginning of the BadgerCare program, through September 2000, the end of FFY 2000, and November 2000, the most recent month's data on HMO enrollment. As the table illustrates, total HMO enrollment has increased from 180,963 in July 1999 to 233,283 in September 2000.

Month of HMO Enrollment	Medicaid Enrollees	BadgerCare Enrollees	Total
July 1999	180,963		180,963
September 2000	183,513	49,770	233,283
November 2000	182,198	51,656	233,854

8. Coordination with other programs

NC

9. Crowd-out

Current federal policy on CHIP programs buy-in of employer-sponsored insurance (ESI) prevents states from buy-in if the recipient's employer pays less than 60 percent of the family premium. This lower limit to ESI subsidy rates artificially lowers the target population of BadgerCare recipients who could be bought in to ESI in a cost-effective manner.

Measuring crowd-out that occurs as a result of BadgerCare, or any other singular public insurance program is problematic. Wisconsin Family Health Survey and Medicaid eligibility data are non-longitudinal measures of private and public program participation, and as such, subject to other factors that may overstate crowd-out, including:

- Rising employer premium costs
- Increased employee cost sharing

- Variations in employment
- Private health insurance verification

Current systems report movement between private and public coverage, not of crowd-out as defined, i.e., individuals dropping private coverage for public coverage.

10. Other

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: FFY 2000 starts October 1, 1999 and ends September 30, 2000.

	FFY 2000 Costs	FFY 2001	FFY 2002
Benefit Costs			
Insurance payments			
Managed care	19,259,694	19,837,484	20,432,609
per member/per month rate X # of eligibles			
Fee for Service	9,463,643	9,747,552	10,039,978
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)	(672,072)	(692,234)	(713,001)
Net Benefit Costs	28,051,265	28,892,802	29,759,586
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other	2,182,747	2,248,229	2,315,675
Total Administration Costs	2,182,747	2,248,229	2,315,675
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)	21,511,500	22,265,837	22,773,435
State Share	8,722,512	8,875,194	9,301,826
TOTAL PROGRAM COSTS	30,234,012	31,141,031	32,075,261

4.2 Please identify the total State expenditures for family coverage during FFY 2000.

Total premium reimbursement and
wrap-around cost = $2,502

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
__X__ Other (specify) premium revenue

1. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No.

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1

Program Name	Medicaid Expansion SCHIP Program	Separate SCHIP program
Provides presumptive eligibility for children	**X** **`No** **___ Yes, for whom and how long?**	**___ No** **___ Yes, for whom and how long?**
Provides retroactive eligibility	**X** **No** **___ Yes, for whom and how long?**	**___ No** **___ Yes, for whom and how long?**
Administers eligibility determination	**___ State Medicaid eligibility staff** **___ Contractor** **___ Community-based organizations** **___ Insurance agents** **___ MCO staff** **X Other *(specify)*** County administered/ state supervised _____	**___ State Medicaid eligibility staff** **___ Contractor** **___ Community-based organizations** **___ Insurance agents** **___ MCO staff** **___ Other *(specify)*** _____
Has joint application for Medicaid and SCHIP	**___ No** **X Yes**	**___ No** **___ Yes**
Has a mail-in application	**X** **No** **__ Yes**	**___ No** **___ Yes**
Can apply for program over phone	**X** **No** **___ Yes**	**___ No** **___ Yes**

Table 5.1		
Program Name	**Medicaid Expansion SCHIP Program**	**Separate SCHIP program**
Can apply for program over internet	**X** **No** **___** **Yes**	**___** **No** **___** **Yes**
Requires face-to-face interview during initial application	**___** **No** **X** **Yes**	**___** **No** **___** **Yes**
Requires child to be uninsured for a minimum amount of time prior to enrollment	**___** **No** **X** **Yes, specify number of months** 3 Months **What exemptions do you provide?** Good Cause exemptions: a. The person was covered by insurance that was provided by a subscriber through is or her employer, and the subscribers employment ended for reason other than voluntary. b. The person was covered by insurance that was provided by a subscriber through his or her employer, and the subscriber changed to a new employer who does not offer family coverage. c. The person was covered by insurance that was provided by a subscriber through his or her employer, and the subscriber's employer discontinued health plan coverage for all employees. d. COBRA continuation coverage was exhausted. e. Any other reason determined by the department to be a	**___** **No** **___** **Yes, specify number of months _____** **What exemptions do you provide?**

Table 5.1		
Program Name	**Medicaid Expansion SCHIP Program**	**Separate SCHIP program**
	good cause reason.	
Provides period of continuous coverage regardless of income changes	**X** **No** **___** **Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period**	**___** **No** **___** **Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period**
Imposes premiums or enrollment fees	**___** **No** **X** **Yes, how much?** 3% of total family income **Who Can Pay?** **___** **Employer** **X** **Family** **___** **Absent parent** **___** **Private donations/ sponsorship** **___** **Other (specify)** **_____**	**___** **No** **___** **Yes, how much? ____** **Who Can Pay?** **___** **Employer** **___** **Family** **___** **Absent parent** **___** **Private donations/ sponsorship** **___** **Other (specify)**
Imposes copayments or coinsurance	**X** **No** **___** **Yes**	**___** **No** **___** **Yes**
Has a passive redetermination process	**X** **No** **___** **Yes, please define process**	**___** **No** **___** **Yes, please define process**

5.2 Please explain how the redetermination process differs from the initial application process.

NC

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal Poverty Level (FPL), for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher

185% of FPL for children under age 6
100% of FPL for children aged 6 to under age 19
___% of FPL for children aged _____

Medicaid SCHIP Expansion

185% of FPL for children aged under age 19 (who are applicants)
200% of FPL for children aged under age 19 (who are recipients)
___% of FPL for children aged _____

State-Designed SCHIP Program

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ No ____ Yes

If yes, please report rules for applicants (initial enrollment). NC

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$ 90	$ 90	$
Self-employment expenses	$	$	$
Alimony payments Received	$	$	$

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Paid	$	$	$
Child support payments Received	$ 50	$ 50	$
Paid	$	$	$
Child care expenses	$ 175/200	$ 175/200	$
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

X No ____ Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

X No ____ Yes, specify countable or allowable level of asset test_____

State-Designed SCHIP program

___ No ____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

___ No ____ Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000?

X No ____ Yes

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(October 1, 2000 through September 30, 2001)? Please comment on why the changes are planned.

May reduce income limit - depends on funding authorized for FFY 2001.

1. Family coverage

2. Employer sponsored insurance buy-in

The current policy of the BadgerCare program allows employer buy-in when the employer share of premiums is no less than 60 percent and no greater than eighty. Under this plan, the State has had limited success in leveraging the employer share of health insurance premiums for BadgerCare enrollees.

As a result, the State is preparing a State Plan Amendment to lower the amount the employer contribution from 60 percent of the premium cost to 50 percent. Analysis shows that an equal share of employers pay between 50 and 60 percent of the premium cost as those that pay in the 60 to 80 percent range.

Through September 30, 2000, seven individuals have been enrolled in their employer-sponsored plan as part of the BadgerCare program. In addition, twenty-one enrollees have been determined to be cost-effective to buy-in at a later date.

Analysis of Employer Buy-In

Documentation through September 30, 2000, shows a total of 1,363 eligible individuals were identified as having access to employer-sponsored group health coverage that met HIPAA requirements. Of these, a total of 297 or 22 percent of these eligible individuals had access to family coverage where the employer pays between 60 and 80 percent of the premiums. Similarly, 286 eligible individuals, or 21 percent had access to employer-sponsored insurance where the employer contributes in a range between 50 and 60 percent of the premium. Unfortunately, under the current proposed rules, the overall cost effectiveness of buying in these eligible individuals cannot be considered as an option.

Of the 297 that were determined to have access to employer coverage where the employer pays between 60 and 80 percent, 108 individuals either left the job or were no longer eligible for BadgerCare. Another 75 individuals were covered under their

employer plan.

3. 1115 waiver

On March 10, 2000, the DHFS submitted to the HCFA an amendment to our Medicaid Section 1115 Demonstration Waiver application for BadgerCare. The waiver amendment requested HCFA approval for the following proposed changes in our BadgerCare waiver:

- Effective for July 1, 2000, Wisconsin would claim Title XXI funding for services provided to the custodial parents and custodial spouses of those parents (Demonstration Population 2) of BadgerCare children.

- Wisconsin will discontinue applying cost-sharing to American Indian/ Alaskan Native children. This policy will be implemented regardless of whether the waiver is approved or rejected by HCFA, since it is now Federal policy for S-CHIP programs.

HCFA issued general guidelines to states for federal considerations in reviewing Title XXI Section 1115 proposed demonstration projects. These guidelines were issued on July 31, 2000.

- On August 3, 2000, Wisconsin received specific questions on our March 10, 2000, BadgerCare Section 1115 Waiver Amendment from HCFA's Director of the Family and Children's Health Programs Group, Cindy Mann. These specific questions were based on the general HCFA guidelines.

  - Wisconsin responded to HCFA's questions and guidelines for responses on September 14, 2000. Wisconsin made the following assurances in this response:

    - The request for Title XXI funding would be limited to parents between 100 percent and 200 percent of the FPL.

    - Wisconsin is committed to enrolling all uninsured low-income children in the state into either Medicaid or BadgerCare.

    - Wisconsin has no immediate plans to implement the "enrollment trigger."

    - The Wisconsin Medicaid/BadgerCare program complies with three out of five preferred enrollment strategies in accordance with HCFA Title XXI waiver requirements: a joint mail-in application and common application procedure; elimination of an asset test; and, a mail-in redetermination process.

- A conference call with HCFA in early October raised additional questions. The Department prepared a supplemental response to our September 14, 2000, submission based on HCFA's comments. Our supplemental response was sent to HCFA on November 28, 2000.

- Wisconsin is committing funding and efforts for continued targeted outreach to families who have not applied for BadgerCare: immigrant families, higher-income families, and families with adolescent children.

4. Eligibility including presumptive and continuous eligibility

NC

5. Outreach

NC

6. Enrollment/redetermination process

1/01-One page paper application for Family Medicaid/BadgerCare was implemented.
7/01-Statewide mail-in application option for Family Medicaid/BadgerCare will be implemented.
7/01-Will implement revised, streamlined verification policies for Family Medicaid/BadgerCare.

7. Contracting

- The DHFS will begin planning changes to the CY 2002 – 2003 Medicaid/BadgerCare HMO around March 2001.

8. Other

ATTACHMENT 1

INCEPTION TO DATE	Nov. 30 1999	April 26 2000	June 5 2000	July 31 2000	*Aug. 31 2000	Sept. 30 2000	Oct. 31 2000
EVIC STATISTICS							
EVICs sent	11,590	25,291	28,830	33,097	35,054	37,788	40,630
EVICs returned	7,302	16,347	18,304	21,744	23,611	25,077	27,003
No longer employed	2,877	4,940	5,561	6,361	6,697	7,074	7,602
Currently employed	4,425	11,281	12,743	15,383	16,914	18,003	19,401
EVIC RESPONSES/CURRENTLY EMPLOYED							
No access to family coverage	2,829	6,756	7,432	8,533	8,949	9,447	10,067
Access to state plan	0	233	288	380	426	469	535
No access to HIPAA std plan	71	110	153	191	201	206	209
Employer plan self funded	1,017	1,801	2,086	2,536	2,693	2,938	3,257
Access18 month/80% employer contribute	0	1,017	1,159	1,426	1,515	1,620	1,760
Currently insured	0	94	242	451	526	630	760
In processing/ follow up/unable to process	0	363	335	634	1,304	1,330	1,348
Access to employer HIPAA plan	508	907	1,048	1,232	1,300	1,363	1,465
Total	4,425	11,281	12,743	15,383	16,914	18,003	19,401
EMPLOYER CONTRIBUTION/HIPAA PLAN							
0 - 9%	48	121	144	176	187	192	200
10 - 19%	20	82	96	108	114	117	124
20 - 29%	57	99	110	123	134	143	149
30 - 39%	38	88	95	101	106	111	120
40 - 49%	33	81	92	105	116	126	139
50 - 59%	102	201	227	267	275	286	303
60 - 79%	193	186	216	269	284	297	330
80% or more	17	49	68	83	84	91	100
Total	508	907	1,048	1,232	1,300	1,363	1,465
60 – 79% EMPLOYER CONTRIBUTION/HIPPA PLAN							
No longer employed	0	3	10	29	43	43	43
No longer BC eligible	0	8	22	64	62	65	67
Currently covered by employer insurance	0	21	21	66	75	75	75
Employer no longer offers coverage	0	1	1	1	1	1	1
Cases with Children not BC Eligible					25	29	47

INCEPTION TO DATE	Nov. 30 1999	April 26 2000	June 5 2000	July 31 2000	*Aug. 31 2000	Sept. 30 2000	Oct. 31 2000
Need additional info from employer	0	135	137	63	46	50	52
Cost effectiveness test run	0	18	25	46	32	34	45
Total	0	186	216	269	284	297	330
COST EFFECTIVENESS TEST							
Cost effective for buy in	0	7	6	6	7	7	7
Cost effective for future buy in	0	8	16	34	19	21	30
Not cost effective for buy in	0	3	3	6	6	6	8
Total	0	18	25	46	32	34	45
Total cases bought in to date	0	2	4	6	7	7	7

ATTACHMENT 2

Table 4.2.3 – Total for CHIP Medicaid Expansion, Section 1115 Waiver for Adults, ESI, and Family Coverage April 1, 1999 – February 29, 2000			
Reason Code for Discontinuation of Coverage	**Description**	**Individuals**	**Percentage of Total for Individuals**
5	Failed to cooperate with the Child Support agency.	261	2.00%
14	Income exceeds the net income limit.	0	
19	Is already receiving this assistance.	9	.06%
28	No person meets program requirements.	1	
30	There are fewer people eligible for this program.	0	
31	Due to death of the individual.	18	.14%
32	Individual in the same case but different category.	9,853	74.05%
39	Is neither a citizen nor a qualifying alien.	13	.10%
60	Failed to cooperate with Third Party Liability requirements.	3	
66	Unearned income increased.	0	
68	Already receives MA through SSI.	106	.80%
80	Declaration of citizenship not completed.	3	
84	Is not in a qualifying living arrangement.	245	1.84%
90	Not cooperating with Medical Support Liability requirements.	2	
93	Refuses to give or get a Social Security Number.	6	
112	Did not verify information.	7	
113	Failed to provide information.	2	
114	Primary person requested to exclude this person.	85	.64%
115	Does not have a qualifying relationship to Primary Person.	11	.08%
116	This person does not meet individual program requirements.	1	

Table 4.2.3 – Total for CHIP Medicaid Expansion, Section 1115 Waiver for Adults, ESI, and Family Coverage April 1, 1999 – February 29, 2000			
Reason Code for Discontinuation of Coverage	**Description**	**Individuals**	**Percentage of Total for Individuals**
132	Income from self-employment has increased.	0	
141	Does not meet program requirements.	2,679	20.14%
144	Application denied. Individual must reapply.	0	
236	S/he does not reside in Wisconsin.	0	
237	S/he does not intend to reside in Wisconsin	0	
279	Is not a parent or stepparent of a child under the age of 19.	0	
280	Is covered by an insurance plan.	0	
281	Had health plan coverage in the last 3 months.	0	
283	Is not cooperating with the premium payment program (HIPP).	0	
284	Access to health plan-employer pays 80% or more of premium.	0	
287	Can't receive BadgerCare until restrictive re-enrollment ends.	0	
290	Chose to meet a MA deductible rather than BadgerCare.	0	
295	You must request Medicaid to receive BadgerCare.	0	
296	You have not paid your premium.	0	
TOTALS		**13,305**	

ATTACHMENT 3

INCEPTION TO DATE	Nov. 30 1999	April 26 2000	June 5 2000	July 31 2000	*Aug. 31 2000	Sept. 30 2000	Oct. 31 2000
EVIC STATISTICS ANALYSIS							
% EVICs returned	63	64.6	63.5	65.7	67.4	66.4	66.5
% Returned no longer employed	39.4	30.2	30.4	29.2	28.4	28.2	28.1
% Returned currently employed	60.6	69	69.6	70.7	71.6	71.8	71.8
EVIC RESPONSES/CURRENTLY EMPLOYED							
% Employed/no access to family coverage	63.9	59.9	58.3	55.5	52.9	52.5	51.9
% Employed/access to state plan	0	2.1	2.3	2.5	2.5	2.6	2.8
% Employed/no access to HIPAA plan	1.6	1	1.2	1.2	1.2	1.2	1
% Employed/employer plan self funded	23	16	16.4	16.5	15.9	16.3	16.8
% Employed/18 month access-employer 80%	0	9	9.1	9.3	9	9	9
% Employed/currently insured	0	0.8	1.9	2.9	3.1	3.5	3.9
% Employed in processing/follow up/	0	3.2	2.6	4.2	7.7	7.3	6.9
% Employed/access to employer HIPAA plan	11.5	8	8.2	8	7.7	7.6	7.6
EMPLOYER CONTRIBUTION/HIPAA PLAN							
% HIPAA plan/ employer contribution 0-49%	38.6	51.9	51.2	49.7	50.5	50.6	50
% HIPAA plan/employer contribution 50-59%	20	22.1	21.7	21.7	21.2	21	20.7
% HIPAA plan/employer contribution 60-79%	40	20.5	20.6	20.8	21.8	21.8	22.5
% HIPAA plan/employer contribution 80% +	3.3	5.4	6.5	6.7	6.5	6.6	6.8
60-79% EMPLOYER CONTRIBUTION/HIPAA PLAN							
% No longer employed	0	1.6	4.6	10.8	15.1	14.5	13
% No longer eligible for BC	0	4.3	10.2	23.8	21.8	21.9	20.3
% Currently covered by employer insurance	0	11.3	9.7	24.5	26.4	25.3	22.7
% Employer no longer offers	0	0	0	0	0	0	0

INCEPTION TO DATE	Nov. 30 1999	April 26 2000	June 5 2000	July 31 2000	*Aug. 31 2000	Sept. 30 2000	Oct. 31 2000
insurance							
% Cases with children not BC eligible					8.8	9.8	14.2
% Need additional information from employer	0	72.6	63.4	23.4	16.2	16.8	15.8
% Cost effectiveness test run	0	9.7	11.6	17.1	11.3	11.4	13.6
COST EFFECTIVNESS TEST							
% Cost effective to buy in	0	83.3	88	87	81.2	82.4	82.2
% Not cost effective to buy in	0	16.7	12	13	18.8	17.6	17.8
CASES BOUGHT INTO EMPLOYER PLAN							
% Of total EVICs sent	0	0	0	0	0	0	0
% Of total EVICs returned	0	0	0	0	0	0	0
% Of total currently employed	0	0	0	0	0	0	0
% Access HIPAA plan/employer pay 60-79%	0	0.1	1.8	2.2	2.5	2.3	2.1